Justification

In 2001 the Central Blood Bank in Kabul tested 9,716 samples of blood and found 6 cases of HIV. This number has since grown to 34 (as of October 2004).

ora international is concerned that the actual total number of cases of HIV in Afghanistan may be far larger than has been officially recorded.

This concern arises from the following factors:

1. The blood samples, analysed by the Central Blood Bank in Kabul, are donated by volunteers. The resulting figures are therefore not representative of the population of Afghanistan as a whole. The total population of Afghanistan is around 28,500,000[6].

2. During its HIV/AIDS work in Pakistan *ora international* has counselled HIV positive people who contracted HIV whilst in counties on the Arabian Peninsula. It was observed that many cases of HIV/AIDS came into Pakistan through these Gulf States. It is highly probable that this same phenomenon will affect neighbouring Afghanistan, especially as more than 3.5 million refugees have returned to the country from various locations since 2001[7].
   It is known that hundreds of Afghans, especially those from the Afghan provinces of Paktia, Paktika and Khost have been working in the Gulf States; as have many people from the northern Pakistani provinces of Miransha, Kohat, Banu and Tal. These provinces of Pakistan border 3 southern Afghan provinces at a point where the border between the two countries is extremely porous.

3. Official estimates of the rates of HIV/AIDS infection in any country have consistently proven to be lower than is actually the case. This discrepancy between official estimates and the real rate of infection may be even more marked in Afghanistan where the prevailing 'shame and honour' culture ensures issues involving the 'shameful' act of sex are not discussed and the existence of sexually-transmitted infections, such as HIV, will not readily be admitted to.

4. The existence of the abovementioned shame and honour culture in Afghanistan means it can be safely assumed that anyone suspecting that they are HIV positive, and that their blood will be tested if donated, would be highly unlikely to volunteer as a blood donor. This reinforces the suspicion that official records present a far lower HIV prevalence rate than is truly the case amongst the general population.

The justifiable concern that there may be a large number of cases of HIV/AIDS in Afghanistan led *ora international* to conduct a survey, initially in Kabul, of the organisations working in the field of HIV/AIDS and of groups at high risk of contracting STI's and HIV/AIDS. It was felt that the time was now right to obtain an accurate picture of the prevalence of HIV/AIDS and STI's and to begin timely interventions to curb the spread of STI's and HIV/AIDS in Afghanistan.

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[6] United States Central Intelligence Agency, Afghanistan in *"The World Fact Book"* [Online] Available at http://www.cia.gov/cia/publications/factbook. [2005, 25th April]
[7] UNHCR, *"Return to Afghanistan"* [Online] Available at http://www.unhcr.ch/cgi-bin/texis/vtx/afghan. [2005, 25th April]

***Aim of the survey*:**

The aim of this survey is:

a. to identify what organisations are involved in HIV/AIDS work
b. to identify groups at high risk of contracting STI's and/or HIV/AIDS

Armed with this information *ora international's* Kabul HIV/AIDS team can better design a programme to contribute to a reduction in the spread of HIV/AIDS in the city.

Awareness raising will also take place whenever people are met, whether members and representatives of the high risk groups, Government officials or NGO personnel.

Background Information

***Kabul*:** The first population census of Kabul city was undertaken in 1965/66 and recorded a total population of 435,000. The male population of 243,000 represented a clear majority over the city's 192,000 females. By the next census in 1979 the population of Kabul had more than doubled to 931,000, with males again making up the majority of the city's residents. Seven years later the 1986 census showed that the population of Kabul exceeded 1 million for the first time in the city's history.

The most recent census of Kabul was carried out in 1999-2000 and recorded a population of 1,781,000. It also showed that for the first time females outnumbered males in the city. The official figures were 888,200 males and 892,800 females. Since the previous census, continued war and conflict had forced significant numbers of people out of Kabul entirely, had left them internally displaced between city districts or conversely had forced people to move into the city from peri-urban areas to seek assistance.

These social upheavals are mirrored in the changing demographic profile of Kabul over the last decades. By 2000 58% of families in Kabul were internally displaced or returnee families. Children under the age of 15 constituted nearly 57% of the city's population. The average number of members in a family was 6.42 persons and 4% of women were classified as widows and "their own family's leaders". This means there were around 18,000 female-headed households in Kabul in 2000 when, as the Population Survey of that year stated, "in spite of the expansion of urban areas, the essential facilities have stayed limited". Assuming a 2% annual population growth rate and taking into account the large influx of returning refugees in 2002, the population in early 2003; the time of UNODC's assessment; is estimated to be around 2.5 million people.[8]

During 2002 1.8 million refugees returned to Afghanistan, mostly from neighbouring countries. The majority of returnees repatriated from Pakistan. In fact 85% of the total number of returnees, 1.54 million people, returned from Pakistan. 252,811 people (14% of all returnees) returned from Iran. Of those returning to Afghanistan from Pakistan, 52% (792,046 people) were from NWFP. Of the total number of refugees returning, 651,732 (37%) returned to Kabul province, most to the city of Kabul itself.[9]

Internally Displaced Persons: Although there is a risk of returned refugees carrying and spreading HIV/AIDS in Kabul there is a greater danger of them being stigmatised because of this risk. According to an IOM brief there are currently an estimated 440,000 people displaced by conflict and natural disasters in camps and cities across Afghanistan.[10] "The Ministry of Refugees and Repatriation with partners facilitates a program for voluntary, safe and gradual return of an estimated 1.2 million refugees and 300,000 internally displaced persons [IDP's]".[11]

[8] UNODC, *"Afghanistan, Community drug profile #5 - an assessment of problem drug use in Kabul city"*, Kabul, UNODC, July 2003.
[9] UNODC, *"Afghanistan, Community drug profile #5 - an assessment of problem drug use in Kabul city"*, Kabul, UNODC, July 2003.
[10] IOM, "*Press Briefing notes 9 July 02*"[Online] Available at http://www.releifweb.int. [2004]
[11] Ministry of Public Health of the Transitional Islamic Government of Afghanistan, *"HIV/AIDS & STI National Strategic plan for Afghanistan 2003-2007"*, Kabul, Ministry of Public Health of the Transitional Islamic Government of Afghanistan, September 2003, p7.

Condom Use and Knowledge of HIV/AIDS: A Multiple Indicator Cluster Survey conducted in the year 2000 reported that contraception is currently used by approximately 2% of married women in the Southeastern region of Afghanistan and by 8% of married women in the Eastern region. Injectable contraceptives appeared to be the most common form of birth control used and condom use was reported to be low. Condoms are available through Mother-Child Health Clinics, pharmacies and shops. Street-side vendors have even been observed with condoms for sale. Some NGO's, such as Marie Stopes International, are initiating social marketing projects in Afghanistan. Social Marketing involves supplying condoms to the market at low cost to encourage their use.

There are no statistics or data on heterosexual multi-partner activities in Afghanistan nor on levels of knowledge about HIV/AIDS".

Sexual Abuse and Violence: The March 2002 ECOSOC report into violence against women and girls in Afghanistan, its consequences and causes, highlights several instances of rape, sexual assault, forced prostitution and forced marriage. The protracted civil war and consequent militarisation of Afghan society led to an increase in the number of abductions of young girls and women by fighters from the various Mujahideen factions.

It is difficult to obtain exact numbers on sexual violence and abduction, as families are reluctant to come forward and report cases of abductions due to the social stigma attached to having a daughter or sister kidnapped or sold for sex.

54 % of girls under the age of 18 were reported to be married. [12]

ora international: *ora international* is a non-governmental, non-profit organisation operating in more than 30 countries in the world. In Pakistan and Afghanistan *ora international* has been working in the areas of health and education since 1992.
ora's HIV/AIDS Department was established in Peshawar, North West Frontier Province (NWFP), Pakistan in 1995. This department provides HIV/AIDS awareness raising, education and counselling services to HIV positive people and their families, commercial sex workers, truck drivers, school students and medical staff.

During the last eight years *ora's* HIV/AIDS department has been successful in broadcasting information to people about this deadly disease. The program of awareness raising was initially aimed at young people. However the program has developed to incorporate a number of other groups in all parts of the NWFP, including higher secondary schools, vocational technical training institutions, professional colleges and nursing training centres.
ora also has well established intervention programs in Afghan educational institutions based in Peshawar and in refugee camps in other parts of NWFP.

The HIV/AIDS team in Pakistan has been able to extend its awareness raising work to parks and bus stands and has received positive responses from the general public. Moreover *ora's* work with lorry drivers has been extremely useful and has opened new doors for awareness and intervention work. We have also started intervention programs amongst high-risk groups including male dancers (Hijras), female commercial sex workers and the beggar community.

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[12] Ministry of Public Health of the Transitional Islamic Government of Afghanistan, "*HIV/AIDS & STI National Strategic plan for Afghanistan 2003-2007*", Kabul, Ministry of Public Health of the Transitional Islamic Government of Afghanistan, September 2003, p8.

ora's female HIV/AIDS team has begun visiting wards in Afghan and Pakistani hospitals, meeting patients and their relatives. Intervention work is also being carried out with HIV positive people and their families.

For more than eight years *ora international* has been developing and printing hundreds of educational, awareness raising and training materials in the field of HIV/AIDS. The majority of these materials have been developed for an Afghan audience, while some of the materials have been tailored for Pakistanis.

ora's HIV/AIDS team in Pakistan runs a counselling centre for HIV positive people in University Town, Peshawar. This centre was established with the assistance of UNAIDS (Islamabad), the National Institute of Health and the Provincial AIDS Control Programme (NWFP). Patients are referred to the *ora* HIV/AIDS team from hospitals and NGO's for counselling and for onward referral for HIV testing to the Blood Bank or other Serology Laboratories.

During the past eight years in which *ora* has worked with HIV positive people and high-risk groups, we as an organisation have begun to understand the difficulties of addressing extremely sensitive subjects such as HIV/AIDS in a 'shame culture'. However we also have found a growing acceptance and understanding of HIV/AIDS, especially amongst school students.

School students in Northern Pakistan were previously unable to share private issues or ask questions about HIV/AIDS, but now these same school students readily ask *ora's* HIV/AIDS team questions about the disease and are willing to share private issues with team members. Through this contact we are slowly learning about the differences in sexual behaviour in the two countries of Afghanistan and Pakistan and this will help in setting up an effective long-term programme in Afghanistan.

Achievements of ora international's HIV/AIDS department since 1995

- 4 districts of NWFP, Pakistan have been covered during and 150,000 youth (both male and female) attending educational institutes have been reached.
- 300 male and 200 female teachers have been trained.
- 300 Islamic religious leaders in the Kohat district have been trained on the issue of HIV/AIDS.
- 500 Madrasa students have been trained in the Kohat district.
- A drama video entitled "The Message" has been produced in the Pashto language. This has been shown on national television and is used in schools. It addresses the sociological, psychological and economic implications of AIDS. It has been a vital tool in the fight for the reduction of the stigma attached to HIV/AIDS.
- 20,000 Afghan youth have been reached.
- The team has established contact with 120 male dancers, some of whom are Eunuchs. Ten male dancers/transvestites have been trained as peer educators in different parts of the NWFP of Pakistan.

- The HIV/AIDS Department is in contact with 35 female commercial sex workers in the region. Although there is no formal 'red-light district', there is a sex-industry in the NWFP and reaching out to the sex workers in the NWFP is difficult as they change location frequently for ensure their own safety.
- A tailoring programme has been established to provide female members of the beggar community with an alternative source of income and enable them to change high-risk behaviours.
- There is an on-going literacy programme for female sex workers from the bangle-beggar community.
- An HIV/AIDS counselling centre has been set up which is run in co-operation with UNAIDS, the Provincial AIDS Control Programme and the National Institute of Health.



Survey Methodology

The survey team visited ACBAR (Agency Co-ordinating Body for Afghan Relief) and the ANCB (Afghan NGO's Coordination Bureau) to collect the addresses of those International and National NGO's that are active in the health sector. From these lists the team selected organisations active in work such as STI prevention, running Tuberculosis clinics or direct HIV/AIDS work. The distribution list for Aid Medical International's (AMI) "Salamati" magazine was also used to collect the addresses of health focused organisations. This ensured that almost all NGO's active in the health sector were contacted.

Respondents also included hospital and clinic staff and Government Officials. High-risk groups were not included in this initial survey.

Various questionnaires were drawn up to enable the survey team to find out what individuals and organisations are already working in the field of HIV/AIDS and to determine which organisation(s) would be suitable for future co-operation.

ora staff carried out oral interviews with members of high-risk groups using a pre-prepared questionnaire format.

Members of high-risk groups were identified via intermediaries such as local governmental representatives, known in Dari as Wakil-e-guzar, and the go-betweens used by commercial sex workers to contact clients. A Wakil-e-guzar represents the people of an area, although the Wakil-e-guzar is not necessarily elected by the majority of people in the area he represents. They are usually wealthy persons who receive further benefits by representing the Government and the people.

Prostitution intermediaries were identified through cooperation with the Nejat Drug Rehabilitation Centre. *ora's* experience in working with high-risk groups in Northern Pakistan also assisted in the identification of many members of high risks groups.

Districts 1, 2, 3, and 4 of Kabul City were identified as containing the highest numbers of representatives of high-risk groups. The map on page 29 shows these districts.

District 1 contains *Shoor Bazaar*, part of the Old City that functions as Kabul's 'red light district', containing numerous prostitution houses. This area was Kabul's 'red light district' up until the late 1970's and has now resumed its historical position. Within this area prostitution often operates as a 'family business'.
Approximately 30% of District 1 lies in the Shoor Bazaar. The remaining parts of District 1 also house a large number of commercial sex workers, as well as multiple truck drivers, drug users and people with a reasonably high disposable income. A number of cinemas in the area attract young boys who are often used for homosexual prostitution. The area also contains a number of police stations and many hotels with sleeping quarters for truck drivers and other transient people. The *Mussafar Khana* is a well-known place for truck drivers to sleep with many bus stations nearby. In addition District 1 has numerous musicians and male dancers, many of whom are known to provide commercial sex services.

District 2 contains the *De Afghanan* area, a focal point for prostitution. This district contains many intravenous drug users and more intravenous drug use occurs in this area than in District 1. This area also has a number of cinemas but there appears to be less homosexual prostitution in this district than was observed in District 1. The *Froshgah* area of District 2 is a known area for people seeking sexual services to meet with 'pimps' and arrange business. The client will then go elsewhere with the commercial sex worker for sex.

District 3 contains Kabul University and large bus stations providing for passengers travelling to and from Herat and Kandahar.

District 4 contains *Shar-e-Nau,* the main centre for business and merchants. Many wealthy people with high disposable incomes live here, and it has consequently become a focal point for commercial sex workers. The district houses a large cinema that attracts many young people. In addition Shar-e-Nau Park is a centre where client, CSW and pimp often meet.
District 4 also has a number of Chinese restaurants renowned for providing sexual services.

The survey's target groups were widely varied and so a number of different questionnaires were prepared.

Different questionnaires were designed for the following groups:

1. The Blood bank
2. International Non-Governmental Organisations
3. Government Ministries, including the Police Department and the Forensic Medicine Department
4. Clinics and Hospitals
5. High Risk groups

Results

*(i) **The Blood bank***

The poor state of blood transfusion facilities throughout Afghanistan is of primary concern if the spread of AIDS is to be controlled. It is estimated that half of the country's 44 surgery-performing hospitals do not systematically test blood for HIV before transfusions. According to information obtained from the Central Blood Bank and World Health Organisation (WHO) less than 30 % of transfused blood is screened. "A WHO brief states that neither the number of transfusions carried out in Afghanistan nor the number screened for transmissible agents is well documented. The figures usually quoted are around 60,000 transfusions per year with 12,000-16,000 in Kabul alone, of which no more than 30% have been tested for transmissible agents including HIV/AIDS."[13]

In total there are 19 Government HIV testing centres throughout the country, with one testing centre in each province and major hospital; but supplies are limited. This is particularly true of HIV/AIDS testing kits.
Testing kits are donated by WHO, UNICEF and AMI. The Central Blood Bank receives reports from 11 provinces where it has functioning branches. In the remaining 22 provinces the Central Blood Bank's branches are partially functioning or not functioning at all. In these areas blood transfusions are undertaken without any screening for HIV and other Blood Borne Diseases (BBD's).

To date the Central Blood Bank has screened 1,210,000 blood samples for HIV. Up to the end of June 2003 they had tested and confirmed 15 HIV positive blood samples. Of these positive samples 7 were found in the first 6 months of 2003 alone.

During the survey team's visit it was found that people with a rare blood type are offered money in exchange for blood donations. The blood tests are funded by WHO.

*(ii) **National and International Non-Governmental Organisations***

71 organisations in all were given the survey questionnaire and 44 organisations responded (see table next page) of which 15 International NGO's and 24 local NGO's that are all active in the health sector. However half of those NGO's did not have any plans regarding HIV/AIDS activities. A few organisations are involved in Family Planning (FP) related activities.

[13] Ministry of Public Health of the Transitional Islamic Government, *"HIV/AIDS & STI National Strategic plan for Afghanistan 2003-2007"*. Kabul, Ministry of Public Health of the Transitional Islamic Government of Afghanistan, September 2003, p6.

Activity regarding HIV/AIDS	**Number of organisations**
Have no activity regarding HIV/AIDS	21
HIV/AIDS awareness incorporated in their health education programme	4
Blood screening for HIV	2
Activities Planned for future	7
Supporting MoH technically in the field of HIV/AIDS through increasing the level of knowledge and through capacity building of the focal points	2
Providing test materials (reagents and scientific hardware) +HIV/AIDS education material	2
HIV/AIDS education+ distribution of condoms for family planning (FP)	2
Distribution of condoms for FP	1
HIV testing and distribution of condoms for FP	1
HIV/AIDS awareness, Training, publications and resource	1
Diagnosis and treatment of STDs	1
Total	**44**

The International Federation of the Red Cross has a program of STI prevention and is providing syndromic treatment in their clinics as well as training other service providers in the same area.

AMI is supplying HIV testing kits to Maiwand hospital and conducting training for laboratory technicians. They also have reproductive health programmes that include condom programming, but this is primarily for family planning rather than for disease prevention.

In Kabul the Afghan Peace-seeking Women's Council (APWC), a local NGO, is implementing a small project for HIV prevention amongst young people and has developed some leaflets and posters for raising awareness of HIV/AIDS.

(iii) UN agencies

UNICEF

One UNICEF official is working as an advisor in the field of HIV/AIDS for the MoH. He mentioned that the MoH were in the process of developing a strategic plan for Afghanistan regarding HIV/AIDS. The "HIV/AIDS & STI National Strategic Plan for Afghanistan 2003-2007" has now been developed. The UNICEF official told the survey team that bi-monthly meetings are held with NGOs' working in this field.



SURVEY

of

GROUPS AT HIGH RISK OF CONTRACTING SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS IN KABUL

Written by: Dr Farid Bazger M.D. and Andrew T. Young B. Sc. Grad Dip CS
Date: April 2005
Place: Kabul, Afghanistan

(iv) Government Departments

This section of the survey began with the *Department of Forensic (Legal) Medicine*. The reason for this was that the survey team were aware that all illegal cases of adultery (heterosexuality) and pederasty (homosexuality) are referred to this department for confirmation. A meeting was held with the department director who confirmed that this was the case.

The survey team wished to know the number of sexual work cases in the department's records and the department's director was able to say that an average of 3 adultery cases are registered with the department daily. He also provided the survey team with an annual record of heterosexual and homosexual cases:

Type of cases	Number of cases
Illegal heterosexuality (Vaginal sex)	65
Illegal heterosexuality (Vaginal and anal sex)	22
Illegal homosexuality	85
Total	172

The Department was reluctant to provide us more information about the age and ethnic origin of the people involved in the cases and which organisations referred the cases to them.

On 14th June 2003 the survey team interviewed the Director General of the *Crime Department of the Ministry of Interior*. The Director General informed us that there were no cases of prostitution amongst their case files, nor did they have any record of persons being imprisoned as a result of prostitution. He introduced us to the Director of Detectives of the Crime Department of the Ministry of the Interior. The Director of Detectives explained his work regarding the detection of prostitution activities.
The Director of Detention advised the team to contact the *Crime Department of Kabul Governor House*.
After several visits the Director of the Crime Department of Kabul Governor House was able to supply the survey team with 9 places in the Microrayon area of Kabul where commercial sex workers lived and worked.

(v) The Attorney General

On 16th June 2003 the Deputy Attorney General was interviewed.
The Attorney General has a representative in each district of Afghanistan and receives crime statistics from the whole of Afghanistan. The crime statistics are recorded according to the Afghan solar calendar.
According to the crime statistics in the previous solar year of 1381, 103 cases of adultery and 57 cases of pederasty were recorded in Afghanistan.
The United Report of Criminal Cases registered with the Attorney General of Kabul Province and related branches for the time period of 1/11/1381 to 12/12/1381 recorded 23 cases of adultery and 15 cases of pederasty within Kabul province's districts.

(vi) The Ministry of Health (MoH)

The survey team leader spoke with an advisor from the MoH. The advisor mentioned that the MoH is in the process of developing a National Strategic Plan for Afghanistan with regard to HIV/AIDS and are planning to have bi-monthly meetings with relevant International NGO's. The National Strategic Plan has now been developed.

The survey team are encouraged that the Government has set up a focal point for HIV/AIDS prevention and treatment as it indicates a willingness at some levels of Government to begin to take the problem seriously. HIV/AIDS, though currently not among the most pressing public health priorities in Afghanistan, is being given attention by the MoH as a potential danger. The Ministry has also recently submitted a proposal to the Global Fund for HIV/AIDS focussing on vulnerable populations, information and education for young people and blood safety. The MoH established an "HIV/AIDS Technical Working Group" in 2002.

(vii) Other Ministries

Ministry of Women's Affairs

The survey team also visited the Ministry of Women's Affairs' health clinic.
The clinic distributes 15 condoms per month through their family planning programs. The staff of the clinic are all married females. The clinic maintains a medical record of condom distribution and attendance.
The survey team visited a lower department of the Ministry of Women's Affairs and were told that they had no cases of sexual violence recorded during the 18 months they had been functioning as a government department. Officials in the Ministry restated that condoms were handed out to people as part of their family planning activities.

(viii) Clinics and Hospitals

The *Skin and Venereal Diseases Department of the Maiwand Hospital* was visited. They mentioned that skin diseases such as Scabies, Eczema and Leishmaniasis (a skin disease caused by sand flies) are the most common cases in this department. The doctors also told us that people with STI's would visit private doctors rather than going to hospitals in order to keep their affliction secret and avoid being 'shamed'.
The Maiwand Hospital is the only large referral hospital in Afghanistan for the treatment of venereal diseases. The Skin and Venereal Diseases Department of Maiwand Hospital has 60 beds, 20 of which are reserved for female patients. The department's health staff consists of 16 doctors and 8 nurses. At the time the survey team visited the hospital the only patients were people with skin diseases.

(ix) STI's

There is no confirmed data on STI prevalence in Afghanistan. However information from clinical records, particularly records from private clinics in large towns, suggests that there may be a high prevalence of STI's in the country. Private clinics in Kabul report that they regularly treat patients with STI's. Gonorrhoea is the most common STI. Though syphilis testing facilities are available at the Maiwand Hospital in Kabul, there have been no reported cases of syphilis at the hospital for many years.[14]

(x) Discrimination

In 2004, during the survey period, *ora international's* HIV/AIDS team came across an incident where 3 deaths from AIDS had been reported in one family. A father and his two children had died from the disease leaving behind the children's mother, who is also HIV positive.

The father of the family was found to be HIV positive through testing at the Central Blood Bank. After this discovery the Blood Bank asked that the remainder of the family be tested and all were found to be HIV positive. The two children were then referred to the Infectious Diseases Hospital (IDH).

ora international were informed that the staff at the IDH were uncooperative, had no facilities to deal with AIDS patients and had no correct information about HIV/AIDS. As a result they had no idea how to deal with the two patients. Both children were sent home after a few hours and both died within the next 24 hours. The principle reason for death was severe and sustained diarrhoea.

(xi) Representatives of High Risk Groups

A questionnaire was prepared specifically for approaching representatives of the high-risk groups. With the aid of this questionnaire members of the various high-risk groups were identified and approached.
This proved to be a difficult enterprise as quite a number of the members of high risk were afraid to come out in the open and discuss their sexual behaviour. This was especially true of commercial sex workers as prostitution, wide spread though it may be, is illegal. It took the survey team a lot of time to gain the confidence of the members of high-risk groups who responded, while other people refused to be interviewed at all unless offered money.

The population of Kabul city has grown rapidly since the fall of the Taliban government in 2001, with many returning refugees deciding to try and rebuild their lives in Kabul. This influx of people has led to an enormous increase in real estate prices and the cost of commodities. People are desperately looking for jobs and many resort to begging. The streets of Kabul are home to hundreds of beggars and street girls and boys (7-13 years). Anecdotal evidence gathered from our survey questions suggests that many beggars and street children become involved in commercial sex activities.

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[14] Ministry of Public Health of the Transitional Islamic Government, *"HIV/AIDS & STI National Strategic plan for Afghanistan 2003-2007"*. Kabul, Ministry of Public Health of the Transitional Islamic Government of Afghanistan, September 2003, p6

The survey team interviewed a high-ranking Police officer from the *Crime Detection Department of Kabul Governor House* and was told that 20 years ago there were as many as 300 prostitution centres in Kabul's Old City. The Old City was infamous for containing brothels, male and female dancers and commercial sex workers. However nowadays these groups are very mobile and subsequently very difficult to find.

One area of the Old City was known as "Kharabat", meaning 'pot-house'. The residents of the area were called 'kharabati', a term for drunken people who care about nothing. In the course of the civil war that raged throughout the early 1990's the "Kharabat" area of Kabul city was completely destroyed and citizens moved to other parts of Kabul. As a result commercial sex workers have no fixed location or formal "red light district" within Kabul but have spread across the city and run their business in different ways.

> *Asghari is a school student of class 7. When he was between 4 and 5 years old his father died and his mother remarried. Asghari went to live with his grandmother who asked him to begin collecting wood to sell to pay for his upkeep. Asghari found the job very difficult: "Some people were giving me money and started to sexually use me. I was happy with that because it was the easiest way to have money for my grandmother. Now it is my business, even if it is shameful. If there is an other alternative, I will stop it."*

The survey team tried several different ways to contact both male and female commercial sex-workers, but faced difficulties with all approaches. For example when the address of a prostitution centre was found and visited the doors would be locked and the neighbours would say that they had moved location. This happened several times.
Despite these difficulties we did have success in interviewing a number of male and female sex workers.

Appendix 1 gives a background of the male and female sex workers interviewed and their involvement in sex work. Names are withheld for reasons of confidentiality. During this survey period 126 commercial sex workers were interviewed.

(xii) Kabul Governor House Women's Prison

The survey team required a letter of recommendation from the Attorney General to visit the women's prison. The team visited the prison and though not allowed to enter the prison itself, the survey team leader was permitted to speak with prisoners from cell windows.
A female warden was asked to introduce to us women who were in prison because of illegal sex activity.

The first prisoner interviewed was a 19-year-old girl who had been in the prison for 4 months. She said she had been "blamed for introducing girls to boys". The warden informed the survey team leader that she is a professional sex worker.

Another prisoner, around 19 to 20 years old and married, was in the prison because she had escaped from her husband's house. She told us:

> *"We have returned from Iran to Afghanistan 10 months ago. We were in Ghazni province. My husband is a bad man and he started to use me as a commercial sex worker. Every day he invited 3-4 people to our house. He also had one other wife, and both of us were involved in this activity. We looked for an opportunity to escape from our house. Eventually we succeeded; first his other wife escaped and after that I. But now I am here (in prison) because of that."* She said they had no knowledge of condoms.

We were allowed to speak to 3 other prisoners, all of whom were in prison for escaping from their houses, though none were involved in commercial sex work.

(xiii) Truck drivers:

We contacted several truck and bus drivers, but the majority of them refused to be interviewed. However some results could be obtained:

1. Five drivers said they have no contact with sex workers.
2. One driver told us that schoolboys had been coming to their compound at night and asking for very little money in exchange for sexual services. The driver had no information about condoms. He also said that these boys are going to nearby police stations 'all the time' for the same reasons.

Anecdotal evidence gained from interviews with 34 bus and truck drivers in different parts of Kabul city suggested that truck/bus drivers and cleaners have more sex contacts with boys than with women.

(xiv) Anecdotal evidence

A doctor working in the mine clearance agency MDC told the survey team that:

> "*we have transferred one of our staff members who was injured in a mine explosion to the Emergency hospital in Kabul city. Doctors of the hospital asked relatives to donate blood for the victim and 5 of his relatives checked for blood group matching. The blood was also screened for HIV at the Emergency Hospital in Shar-e-Nau and it was found that from these 5 blood samples 3 were HIV positive.*"

(xv) Drug use

Afghanistan is one of the world's largest producers of opium. Opium and heroin abuse appear to be more severe in the areas where those drugs are produced. There is currently no data on the number of Afghans who inject drugs, although indicators suggest there is an increase in intravenous drug use in Kabul, Gardez, Farah and Herat.

Research conducted by the John Hopkins Bloomberg School of Public Health on Pakistani and Afghan drug users at high risk of contracting HIV/AIDS shows that only 16 % of the participants had heard of HIV/AIDS. All of the Afghan drug users interviewed in the research had never used a condom while having sex".[15]

Based on estimated figures of 7,008 heroin users in Kabul city the report calculated that there are an estimated 470 drug users injecting heroin in Kabul.[16]

(xvi) Age, marital status and ethnicity demographics

The survey team interviewed 126 commercial sex workers. 4 were male and 122 were female and all fell within an age range of 14 to 45 years old. The average age of CSW's interviewed was 28 years.

Average number of clients per week	16.8 (17)
Maximum number of clients per week	49
Minimum number of clients per week	1

78% of female commercial sex workers were married, 4% were divorced, 9% were single and 9% were widows.

Divorced	5
Single	11
Widow	11
Married	99
Total	126

88% of commercial sex workers interviewed were Tajik, 6% were Hazara 5% were Uzbek 1% were Pushtun (Obviously this does not mean that these figures are representative for the whole group as the team found that when they were referred to new sex workers by the ones being interviewed that those would belong to the same ethnic group).

Tajik	111
Hazara	8
Uzbek	6
Pashton	1
Total	126

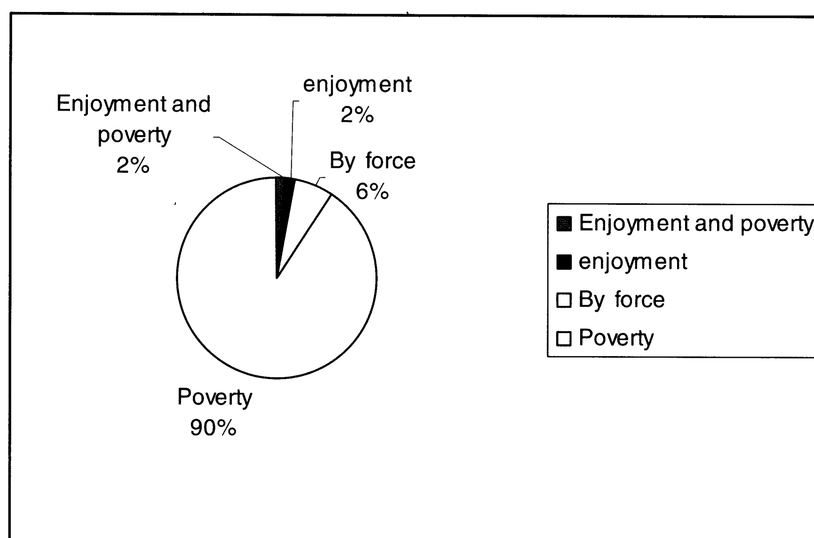
[15] Ministry of Public Health of the Transitional Islamic Government, *"HIV/AIDS & STI National Strategic plan for Afghanistan 2003-2007"*. Kabul, Ministry of Public Health of the Transitional Islamic Government of Afghanistan, September 2003, p6.

[16] UNODC, *"Afghanistan Community Drug Profile #5 - an assessment of problem drug use in Kabul city"*, Kabul, UNODC, July 2003.

(xvii) Causal, temporal, and financial demographics

The survey team found that the length of time commercial sex workers had been involved in commercial sex work varied between 0.5 and 480 months. The average duration of involvement in commercial sex work was 104.6 months.

Of the reasons commercial sex workers gave for commencing commercial sex work 90% stated poverty, 2% stated enjoyment and poverty, 2% stated enjoyment and 6% stated that someone else had forced them into commercial sex work.



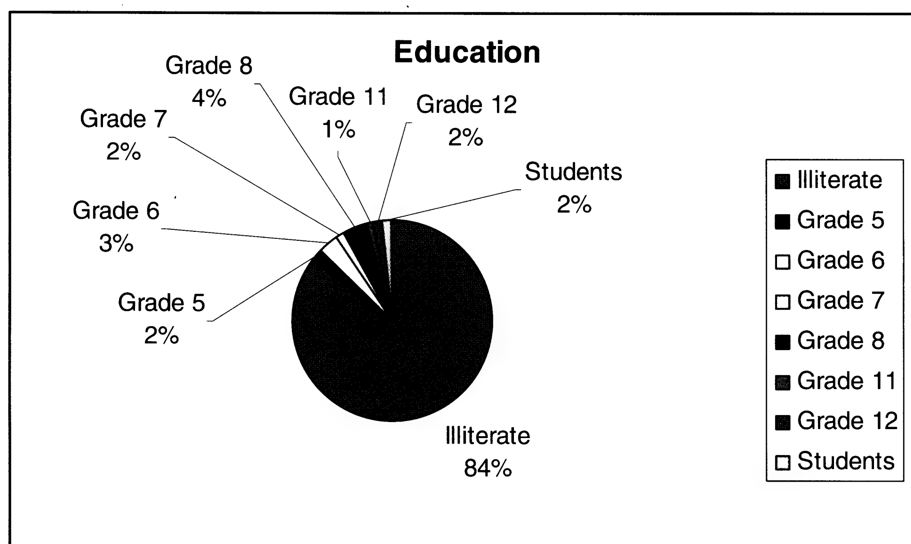
The average number of clients per week was 17 (16.8) clients with the maximum being 49 clients and the minimum 1 client per week.

The average income per client was 2,073 Afs with the maximum being 22,050 Afs and the minimum being 100 Afs for male commercial sex workers and 150 Afs for female commercial sex workers.

(xviii) Education and awareness demographics

1 commercial sex worker (0.8%) interviewed were familiar with condoms also only one (0.8%) had knowledge or information about HIV/AIDS.

84% of commercial sex workers interviewed were found to be illiterate, 2% were currently students, 2% had completed grade 12, 1% had completed grade 11, 4% had completed grade 8, 2% had completed grade 7, 3% had completed grade 6, and 2% had completed grade 5.



(xix) Finding clients

The commercial sex workers interviewed by the survey team found clients through various means. 53% found clients by themselves, 17% found clients through their mother, 15% found clients through their husband, 7% found clients through pimps, 3% found clients through their mother in law, 2% found clients through a sister, 2% found clients through their father and 1% found clients by themselves and others.

Finding customers through:	
Him/herself	65
Through pimps	9
Husband	19
Mother	22
Father	3
Mother in law	4
Sister	3
Other	1
Total	126

Discussion

No base line data on the prevalence of HIV/AIDS or other sexually transmitted infections in Afghanistan is available due to the absence of surveillance mechanisms.

Of the 7 HIV sero-positive cases reported during the year 2003, six occurred among local residents who had not travelled out of the country. The cases reported before the year 2003 were detected among persons who had lived outside the country. The route of infection reported in these cases was heterosexual transmission. [17]
This would appear to contradict the Central Blood Bank's statement that all 34 cases in its records returned from outside countries.

Overall the survey team received fairly poor responses from many of the organisations that had been approached. Much of this lack of response can be put down to security issues and the fact that *ora* had wrong addresses on file for a number of NGO`s. In the current climate of challenging security and rapidly increasing rents many NGO`s have moved, and continue to move, to alternative premises.

Furthermore it was found that 21 out of 44 health related organisations interviewed have no activity regarding HIV/AIDS, few are carrying out screening of transfused blood, few have HIV/AIDS awareness raising activities in their health education programs, and few are either distributing condoms or testing patients for HIV.

The information received from the Police and Forensic Medicine Departments regarding prostitution, when compared to our survey of high-risks groups, stands in stark contrast. The information received from the Afghan Justice and Correctional Authorities however, reinforces the survey team's belief that prisons, as with every country in the world, are a place where HIV can spread quickly. Prisoners need to have HIV/AIDS awareness programs made available to them and need access to treatment for HIV and AIDS.

The Ministry of Health is moving in the right direction with the development of its National Strategic Plan for HIV/AIDS but needs further assistance with the development of the health sector in general. The lack of a functioning health care system in Afghanistan means that the need to address the HIV/AIDS problem will remain in competition for funds with the need to establish an adequate basic health care system. Unless the HIV/AIDS situation in Afghanistan is addressed and adequate funds allocated, an HIV/AIDS epidemic appears to be a disaster waiting to happen.

The records of service provided by Maiwand Hospital to patients with STI`s and HIV/AIDS apply illustrate that social stigma presents a serious barrier to the establishment of a quality service for people affected by STI's in Afghanistan. Honour and shame are strong influencing factors in Afghan society and strategies need to be formulated to overcome the stigma associated with HIV/AIDS. Unless a pro-active stance is taken on this issue the problem is only likely to increase as knowledge of HIV/AIDS increases, as the knowledge that HIV can be transmitted sexually will further stigmatise PLWHA's due to association with the inherently 'shameful' act of sex.

[17] Ministry of Public Health of the Transitional Islamic Government, *"HIV/AIDS & STI National Strategic plan for Afghanistan 2003-2007"*. Kabul, Ministry of Public Health of the Transitional Islamic Government of Afghanistan, September 2003, p5

Discrimination against patients with HIV/AIDS is present amongst health professionals. The case of the deaths of two children from the same family highlighted earlier in this report illustrates 3 major aspects of current discrimination:

1. Stigmatisation: the staff of the Infectious Diseases Hospital did not accept the two patients well simply because they were HIV positive. o*ra international's* HIV/AIDS team strongly believe that if the patients were kept in the hospital and treated correctly they would not have died at that time and their lives could have been prolonged.
2. A Lack of facilities to cope with AIDS patients. No special ward for HIV/AIDS patients exists within the Infectious Diseases Hospital.
3. Lack of training: the staff of the Infectious Diseases Hospital simply did not know what to do when confronted with HIV positive patients. It is possible that if the staff had understood that HIV/AIDS was not dangerous to their own health they may have cooperated in the patient's treatment, rather than discharge the patients prematurely.

The results of the survey of commercial sex workers reveal a number of important points. Poverty is a strong factor in the decision to commence commercial sex work.
Only 9% of commercial sex workers were widowed, a smaller figure than the survey team had anticipated. This fact, combined with the strongly patriarchal nature of Afghan society, leads us to deduce that many male heads of household are either incapable of working due to ill health or a physical handicapped, or cannot find work.

The majority of commercial sex workers know little or nothing about the dangers of HIV/AIDS and about the use of condoms.

There is a disproportionate representation of ethnic groups amongst the commercial sex workers interviewed. Further study of the reasons for this needs to take place. One concern is that all 4 survey team members are of Pushtun ethnicity and this may have biased the survey results. Any future survey needs to ensure that the surveying team includes a variety of ethnic group.

The survey team found no evidence that organised crime syndicates control prostitution in Kabul, however the possibility that this may be the case should remain in the minds of any organisation wishing to tackle prostitution in Afghanistan. Afghanistan is confronting a serious human trafficking problem that is deeply intertwined with the country's many other problems as it emerges from decades of lawlessness.[18] The fact that only 7% of CSW`s interviewed found clients through pimps reinforces the belief that organized crime syndicates do not, as yet, control prostitution in Kabul. Nonetheless the survey results by no means present conclusive proof that this is the case.

[18] IOM, *"Trafficking in Persons; An Analysis of Afghanistan"* [Online] Available at http://www.iom.int/iomwebsite/publication [2005, April 24th]

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Conclusion

There are a number of factors that will help promote the spread of HIV/AIDS in Afghanistan:

- Open borders with no screening for HIV at points of entry, including airports.
- The return of millions of Afghans to the country from various locations.
- Large numbers of internally displaced people.
- Ongoing drug trafficking and drug use that predisposes people to isolation from their families and the community, a lack of employment and a resultant of a lack of income. As a result of these factors drug users often become involved in prostitution as a means of income generation, placing them at a higher risk of contracting HIV/AIDS.
- Intravenous drug use without the use of clean needles
- The arrival in Kabul of workers from many different nations to assist in the reconstruction of the country. During the survey the head of a group of sex workers told us that the influx of foreign workers has attracted thousands of prostitutes to come into Afghanistan from abroad to work.
- The desperate economic situation encountered by widows in Kabul, forcing many into prostitution. Of 60 female prostitutes in Kabul City interviewed by *ora* staff between February 2004 and September 2004, 52 cited poverty as the reason for turning to prostitution (86% of all respondents).
  The price of virtually all commodities in Afghanistan has increased significantly since the fall of the Taliban Government. For example the price of Nan bread has increased from 1 Afghani during Taliban times to an average of 3.5 Afghanis today, while rice has increased from 1,100 Afghanis to 1,500-1,700 Afghanis per 50kg of rice. Bread and rice are the basic food staples in Afghanistan. Although the prices of basic food items were cheaper during Taliban times "the Taliban`s gender-apartheid policies brought about the feminization of poverty".[19]
- Unfamiliarity with condoms, a low literacy rate and low health education.
- A serious lack of knowledge among the majority of medical personnel staff about AIDS signs and symptoms. 3 years ago no material regarding HIV/AIDS existed in the curriculum of any tertiary medical education institutions in Kabul. In 2004 3 subjects at the Medical Faculty of Kabul University provided education about HIV/AIDS: Microbiology (2nd year), Preventative Medicine (5th year) and Internal Medicine (5th year).

Cultural and religious restrictions force people with HIV/AIDS and their families to hide from medical staff and the community. People who suspect they are HIV positive will also seek the same anonymity. This means that the official reported number of HIV/AIDS patients in Afghanistan is likely to represent only the tip of the iceberg.

[19] Zieba, Shorish-Shamley, *"The Plight of Women and Health Care in Afghanistan"*. [Online] Available at http://www.wapha.org/health.html [2004, October 19th]

The lack of education and knowledge in Afghanistan about health in general, and HIV/AIDS in particular, is alarming. With regards to the spread of HIV/AIDS this presents a great risk and is increased by the large influx of refugees returning to Afghanistan from different countries. Even doctors and other health workers seem to have little understanding of the issues related to HIV/AIDS.
ora's experience and expertise in the field of HIV/AIDS leads us to be very much concerned about the potential risk of a widespread HIV/AIDS epidemic in poor and uneducated Afghanistan.
ora international believes an HIV/AIDS prevention, education and awareness programme is now urgently needed and should followed by a counselling programme for HIV positive people.

Further identification of people living with HIV/AIDS (PLWHA) and a needs assessment amongst these groups urgently needs to be undertaken. *ora international* would like to explore the opportunities to establish support groups to facilitate greater involvement in society by PLWHA. We are also seeking to try to decrease the stigma attached to PLWHA.

ora international will start work in 4 districts of Kabul city; districts 1, 2, 3 and 4, all of which are located in the centre of the city. These districts contain the highest number of high-risk and target groups. A number of NGO staff, Government officers and people from the communities in which the survey team worked stated that we should extend our work to Mazar-I-Sharif as they believed prostitution was rife within the city. Moreover many of the long-term commercial sex workers in Kabul originally come from Mazar-I-Sharif.

Acknowledgements

We are very grateful to Tearfund UK and Norwegian Church Aid (NCA) for funding this survey. Our thanks go out to all Afghan national and international non-governmental organisations, UN agencies and governmental organisations that have participated in this survey. We appreciate the time they set apart for filling out our questionnaire forms and for meeting with us and we appreciate their willingness to share information and data with us.

We are very thankful to all respondents who answered our questions honestly and openly in spite of cultural and religious restrictions.

Dr Farid Bazger
Survey Team Leader

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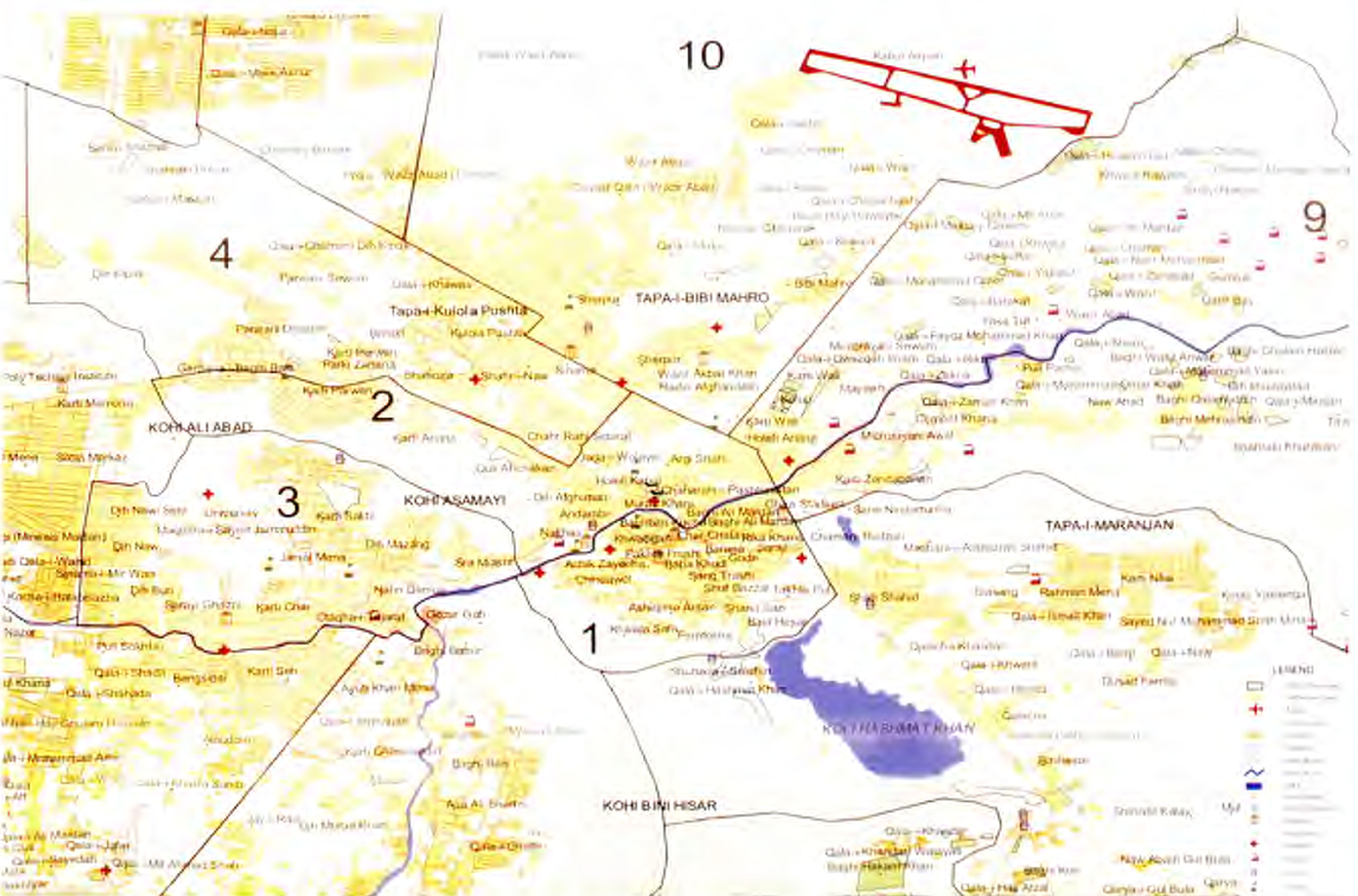
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Appendices

No.	Age in years	Sex	Marital status	Ethnic group	Duration in months	Reason for starting with sex work	No of clients/ week	Ethnicity of the clients	Money received from clients (daily in Afs)	Familiarity with condoms	Information re: HIV/AIDS	Education	Finding customers	Remarks
1	30	F	Married	T	24	Poverty	14	All	3,500	Yes	Yes	Up to class 6	Herself	
2	19	M	Single	T	72	Poverty	21	All (mainly Tajik)	125	No	No	Student of class 7	Himself	
3	18	M	Single	T	36	Poverty	3	All (mainly Tajik)	100	No	No	Student of class 7	Himself	
4	24	F	Single	T	1	Poverty	21	Mixed	2,500	No	No	Illiterate	Herself	Prison
5	15	F	Single	T	0.5	Poverty	21	Afghans and foreigners	14,700	No	No	Class 8	Through another woman	Prison
6	22	F	Married	T	36	Poverty	21	Mixed Afghans	500	No	No	Illiterate	Her husband	Prison
7	24	F	Married	T	24	Poverty	21	Afghans and foreigners	4,500	No	No	Illiterate	Herself	Prison
8	25	F	Married	T	1	Poverty	28	Mixed Afghans	4,900	No	No	Illiterate	Through another woman	Prison
9	18	F	Divorced	H	33	Poverty	7	Iranian	500	No	No	Illiterate	Herself	Shelter
10	17	F	Divorced	H	32	Poverty	28	Iranian	500	No	No	Illiterate	Herself	Shelter
11	18	F	Divorced	H	12	Poverty	21	Iranian	500	No	No	Class 8	Husband	Shelter
12	27	F	Married	H	1	Poverty	21	Afghans and foreigners	22,050	No	No	Illiterate	Herself	Prison
13	35	F	Married	T	24	Poverty	21	Chinese	22,050	No	No	Class 8	Herself	Prison
14	40	F	Married	T	60	Poverty	21	Mixed Afghans	500	No	No	Class 8	Husband	Prison
15	35	F	Married	T	1	Poverty	21	Foreigner s	9,800	No	No	Illiterate	Herself	Prison
16	19	F	Married	T	1	Poverty	21	Foreigner s	9,800	No	No	Illiterate	Through her mother	Prison
17	20	F	Married	T	1	Enjoy ment & poverty	35	Afghans	250	No	No	Illiterate	Husband	Prison
18	32	F	Married	T	2	Poverty	14	Mixed	1,500	No	No	Illiterate	Herself	Prison
19	19	F	Single	T	1	Poverty	21	High Gov't officials	5,500	No	No	Student of class 11th	Herself	Prison
20	35	F	Married	T	2	Poverty	14	Mixed	1,500	No	No	Illiterate	Herself	Prison
21	40	F	Married	T	1	Poverty	14	Afghan	2,500	No	No	Illiterate	Herself	Prison
22	26	F	Married	T	180	Poverty	49	Afghan	3,500	No	No	Illiterate	Through her friend	Prison
23	20	F	Single	T	0.5	Poverty	49	Mixed	3,500	No	No	Illiterate	Through her friend	Prison
24	28	F	Married	T	0,5	Poverty	49	Afghan	3,500	No	No	Illiterate	By their leader	Prison
25	35	F	Married	T	1	Poverty	14	Afghan	2,500	No	No	Illiterate	By herself	Prison
26	28	F	Married	T	10	Poverty	21	Afghan	2,500	No	No	Illiterate	By herself	Prison
27	20	F	Married	T	10	Poverty	14	Afghan	3,000	No	No	Illiterate	By herself	Prison
28	16	F	Single	T	1	Poverty	14	Afghan	2,000	No	No	Illiterate	By herself	Prison
29	17	F	Married	H	24	Poverty	14	Afghan	3,000	No	No	Illiterate	By herself	Prison

No.	Age in years	Sex	Marital status	Ethnic group	Duration in months	Reason for starting with sex work	No of clients/ week	Ethnicity of the clients	Money received from clients (daily in Afs)	Familiarity with condoms	Information re: HIV/AIDS	Education	Finding customers	Remarks
30	19	F	Married	H	120	Poverty	49	Afghan	3,000	No	No	Illiterate	By her mother and herself	
31	37	F	Married	H	300	Poverty	28	Afghan	1,500	No	No	Illiterate	By herself and their leader	
32	19	F	Married	T	36	Poverty	49	Afghan	1,750	No	No	Illiterate	By a third person	
33	30	F	Married	T	24	Poverty	14	Afghan	2,450	No	No	Illiterate	By herself	
34	18	M	Single	T	96	By force	28	Afghan	500		No	Illiterate	By pimp	
35	35	F	Married	T	240	Poverty	14	Afghan	2,000	No	No	Illiterate	By himself	
36	35	F	Married	T	180	Poverty	14	afghan	1,250	No	No	Illiterate	By himself	
37	45	F	Married	T	240	Poverty	7	Afghan	1,750	No	No	Illiterate	by himself	
38	30	F	Married	T	120	Poverty	28	Afghan	750	No	No	Illiterate	By husband	
39	35	F	Married	T	180	Poverty	35	Afghan	750	No	No	Illiterate	By husband	
40	42	F	Married	T	360	Poverty	38	afghan	500	No	No	Illiterate	By himself	
41	47	F	Married	T	360	Poverty	14	Afghan	750	No	No	Illiterate	By himself	
42	20	F	Married	T	84	Poverty	28	Afghan	750	No	No	Illiterate	By her husband	
43	20	F	Married	T	72	Poverty	14	afghan	750	No	No	Illiterate	Himself	
44	18	F	Married	T	96	Poverty	14	Afghan	750	No	No	Illiterate	By her mother	
45	35	F	Married	T	120	Poverty	14	Afghan	1,250	No	No	Illiterate	By him self	
46	50	F	Married	T	480	Forced by her husband	28	Afghan	2,500	No	No	Illiterate	Find by her husband	
47	20	F	Married	T	96	Forced by her husband	28	Afghan	2,500	No	No	illiterate	By her husband	
48	18	F	Married	T	36	Poverty	14	Afghan and foreign	3,675	No	No	Illiterate	By her mother	
49	35	F	Married	T	48	Forced by her husband	28	Afghan	1,050	No	No	Illiterate	By her husband	
50	40	F	Married	T	360	Poverty	35	Afghan	3,675	No	No	Illiterate	By her husband	
51	20	F	Married	T	24	Poverty	21	Afghan and foreign	6,125	No	No	Illiterate	By her husband	
52	19	F	Married	T	96	Forced by her father	28	Afghan and foreign	7,350	No	No	Illiterate	By her father	
53	19	F	Married	T	60	Forced by her father	28	Afghan and foreign	3,675	No	No	Illiterate	By her father	
54	28	F	Single	U z	120	Poverty	35	Afghan	1,075	No	No	Illiterate	By her mother	
55	24	F	Married	T	60	Poverty	24	Afghan	750	No	No	Illiterate	By him self	
56	30	F	Married	T	300	Poverty	24	Afghan	1,250	No	No	Illiterate	By her self	
57	25	F	Married	T	132	By force her mother	24	Afghan	1,075	No	No	Illiterate	By her mother	

No.	Age in years	Sex	Marital status	Ethnic group	Duration in months	Reason for starting with sex work	No of clients/ week	Ethnicity of the clients	Money received from clients (daily in Afs)	Familiarity with condoms	Information re: HIV/AIDS	Education	Finding customers	Remarks
58	23	F	Married	T	96	Poverty	24	Afghan	1,750	No	No	Illiterate	By her mother	
59	16	F	Married	P	36	Poverty	24	Afghan	2,500	No	No	Illiterate	By her husband	
60	45	F	Married	Uz	144	Poverty	49	Afghan	1,500	No	No	Illiterate	By her self	
61	30	F	Married	T	72	By force of her husband	24	Afghan	1,500	No	No	Illiterate	By her husband	
62	35	F	Married	Uz	60	Poverty	24	Afghan	1,500	No	No	Illiterate	By her husband	
63	25	F	Married	T	48	Poverty	24	Afghan	1,500	No	No	Illiterate	By her husband	
64	45	F	Married	T	420	Poverty	49	Afghan	1,500	No	No	Illiterate	By herself	
65	40	F	Married	T	144	Poverty and enjoyment	49	Afghan	1,500	No	No	Illiterate	By herself	
66	40	F	Married	T	180	enjoyment	49	Afghan	750	No	No	Illiterate	By herself	
67	25	F	Married	T	156	Poverty	12	Afghans	1,500	No	No	Illiterate	By brother's wife	
68	25	F	Married	T	84	Poverty	12	Afghans	3,675	No	No	Illiterate	By her mother	
69	40	F	Married	T	360	Poverty	12	Afghans	1,500	No	No	Illiterate	Herself	
70	35	F	Married	T	120	Poverty	12	Afghans	3,675	No	No	Illiterate	Herself	
71	30	F	Married	T	60	Poverty	12	Afghans	1,500	No	No	Illiterate	Herself	
72	20	F	Married	T	12	Poverty	12	Afghans	1,750	No	No	Illiterate	Mother-in- law	
73	35	F	Married	T	24	Poverty	12	Afghans	1,750	No	No	Illiterate	Mother-in- law	
74	30	F	Married	T	36	Poverty	12	Afghans	1,500	No	No	Illiterate	Mother-in- law	
75	30	F	Married	T	36	Poverty	12	Afghans	1,500	No	No	Illiterate	Mother-in- law	
76	35	F	Married	T	240	Poverty	21	Afghans	1,500	No	No	Illiterate	Pimp	
77	30	F	Married	T	180	Poverty	21	Afghans	1,500	No	No	Illiterate	Herself	
78	40	F	Married	T	300	Poverty	12	Afghans	750	No	No	Up to class 6	Herself	
79	14	M	Single	T	36	Poverty	21	Afghans	50-100	No	No	Student	Himself	
80	30	F	Married	T	240	Poverty	12	Afghans	5,500	No	No	Illiterate	Herself	
81	25	F	Married	T	72	Poverty	12	Afghans	5,500	No	No	Illiterate	Herself	
82	30	F	Married	T	120	Poverty	7	Afghans	750	No	No	Illiterate	Herself	
83	35	F	Married	T	60	Poverty	7	Afghans	750	No	No	Illiterate	Herself	
84	35	F	Married	T	180	Poverty	12	Afghans	750	No	No	Illiterate	Herself	
85	20	F	Married	T	60	Poverty	12	Afghans	2,450	No	No	Illiterate	Her mother	
86	30	F	Married	T	180	Poverty	12	Afghans	750	No	No	Illiterate	Herself	
87	25	F	Married	T	60	Poverty	12	Afghans	750	No	No	Illiterate	Her mother	
88	40	F	Married	T	240	Poverty	12	Afghans	750	No	No	Illiterate	Herself	
89	20	F	Married	T	60	Poverty	12	Afghans	750	No	No	Illiterate	Her mother	
90	30	F	Married	T	120	Poverty	12	Afghans	750	No	No	Illiterate	Her mother	
91	40	F	Married	T	240	Poverty	7	Afghans	150	No	No	Illiterate		
92	16	F	Single	T	60	Poverty	7	Afghans	350	No	No	Illiterate	Her sister	
93	23	F	Married	T	60	Poverty	7	Afghans	750	No	No	Class 6	Herself	



10
9
4
3
2
1
TAPA-I-BIBI MAHRO
Tapa-i-Kulola Pushta
KOHI ALI ABAD
KOHI ASAMAYI
TAPA-I-MARANJAN
KOHI BIBI HISAR
KOH-I-HASHMAT KHAN
LEGEND

No.	Age in years	Sex	Marital status	Ethnic group	Duration in months	Reason for starting with sex work	No of clients/ week	Ethnicity of the clients	Money received from clients (daily in Afs)	Familiarity with condoms	Information re: HIV/AIDS	Education	Finding customers	Remarks
94	35	F	Married	T	180	Poverty	7	Afghans	750	No	No	Illiterate	Her husband	
95	28	F	Married	T	72	Poverty	7	Afghans	750	No	No	Illiterate	Herself	
96	35	F	Married	T	120	Poverty	7	Afghans	750	No	No	Illiterate	Her mother	
97	30	F	widow	T	120	Poverty	7	Afghans	550	No	No	Illiterate	Herself	Heroin & opium user
98	30	F	Married	T	60	Poverty	7	Afghans	350	No	No	Illiterate	Herself With few others	Smoking cigarette
99	32	F	Married	T	60	Poverty	7	Afghans	750	No	No	Illiterate	Her sister	
100	28	F	Married	T	60	Poverty	7	Afghans	750	No	No	Illiterate	Herself With few others	
101	40	F	Married	Uz	180	Poverty	7	Afghans	750	No	No	12 grade	Her sister	No
102	39	F	widow	Uz	180	Poverty	7	Afghans	750	No	No	12 grade	Herself and her sister	No
103	35	F	Married	T	96	Poverty	14	Afghans	750	No	No	Illiterate	Her husband	Smoking chilim
104	33	F	Married	T	96	Poverty	7	Afghans	400	No	No	Illiterate	Her husband	Smoking cigarette
105	45	F	Married	H	240	Poverty	14	Afghans	750	No	No	Illiterate	Herself	Smoking cigarette
106	40	F	Widow	T	120	Poverty	7	Afghans	750	No	No	Illiterate	Herself	No
107	35	F	Married	T	240	Poverty	2	Afghans	750	No	No	Illiterate	Herself	No
108	42	F	Married	T	240	Enjoyment	2	Afghans	750	No	No	11 grade	Herself	Smoking cigarette
109	30	F	Married	T	72	Poverty	1	Afghans	750	No	No	Illiterate	Herself	No
110	35	F	Married	T	120	Poverty	7	Afghans	400	No	No	Illiterate	Herself	No
111	19	F	Married	T	48	Poverty	7	Afghans	400	No	No	Illiterate	Her mother	No
112	44	F	Married	T	156	Poverty	1	Afghans	400	No	No	Illiterate	Her mother	No
113	30	F	Widow	T	120	Poverty	1	Afghans	350	No	No	6 grade	Her mother	No
114	31	F	Married	T	60	Poverty	1	Afghans	350	No	No	Illiterate	Her mother	No
115	40	F	Married	Uz	48	Poverty	1	Afghans	350	No	No	Illiterate	Her mother	No
116	19	F	Married	T	36	Poverty	1	Afghans	350	No	No	Illiterate	Her mother	No
117	40	F	widow	T	108	Poverty	1	Afghans	350	No	No	5 grade	Her mother	No
118	30	F	widow	T	48	Poverty	1	Afghans	350	No	No	5 grade	Her mother	No
119	35	F	widow	T	192	Poverty	1	Afghans	350	No	No	5 grade	Her mother	No
120	27	F	widow	T	120	Poverty	1	Afghans	1,000	No	No	8 grade	Her mother	Smoking cigarette
121	19	F	Divorced	T	36	Poverty	1	Afghans	500	No	No	Illiterate	Her father	Smoking cigarette
122	30	F	Widow	T	144	Poverty	1	Afghans	350	No	No	Illiterate	Herself	No
123	30	F	Widow	T	72	Poverty	1	Afghans	400	No	No	Illiterate	Herself	No
124	45	F	Married	T	48	Poverty	1	Afghans	400	No	No	Illiterate	Herself	Smoking huqa
125	30	F	Widow	T	36	Poverty	1	Afghans	300	No	No	Illiterate	Herself	No
126	18	F	Divorced	T	24	Poverty	1	Afghans	350	No	No	Illiterate	Herself	No

List of Abbreviations and Acronyms

ACBAR	-	Agency Coordinating Body for Afghan Relief
AIDS	-	Acquired Immune Deficiency Syndrome
Afs	-	Afghani (the official currency of the Islamic Republic of Afghanistan)
AMI	-	Aid Medical International
ANCB	-	Afghan Non-Governmental Organisations Coordination Bureau
APWC	-	Afghan Peace-seeking Women's Council
BBD's	-	Blood-Borne Diseases
CAF	-	Children's AIDS Fund
CSW	-	Commercial Sex Worker
ECOSOC	-	United Nations Economic and Social Council
HIV	-	Human Immunodeficiency Virus
IDP's	-	Internally Displaced persons
IOM	-	International Organisation for Migration
ISAF	-	International Security Assistance Force
KOR	-	Khatiz Organisation for Rehabilitation
MDC	-	Mine Detection and Dog Centre
MDM	-	Medecins du Monde
MoH	-	Ministry of Public Health of the Government of Afghanistan
NCA	-	Norwegian Church Aid
NGO	-	Non-governmental Organisation
NWFP	-	North West Frontier Province of Pakistan
PLWHA	-	People Living With HIV/AIDS
STI	-	Sexually Transmitted Infection
SCA	-	Swedish Committee for Afghanistan
UN	-	United Nations
UNAIDS	-	United Nations' Joint Programme on HIV/AIDS
UNFPA	-	United Nations' Population Fund
UNICEF	-	United Nations' Children's Fund
UNODC	-	United Nations' Office on Drugs and Crime
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

Executive Summary

Completing an accurate survey of the HIV/AIDS situation in Kabul has taken considerably longer than was initially anticipated. There were two reasons for this:

Firstly, due to a change in management within *ora international* and an increased workload created by the transfer of assets from Pakistan to Kabul, we were unable to begin the survey until May 2003.

Secondly and more significantly the survey team realised that in order to collect meaningful data it needed to invest more time in gaining the confidence of the various representatives of high-risk groups than had originally been assumed.

ora international's HIV/AIDS team is, at this stage, quite small. It comprises three staff members: two male and one female. Throughout June 2003 an expatriate female nurse from the Netherlands aided the project. She brought to the team invaluable experience of professional interaction with the survey's target groups, garnered while working with the same high risk groups in her home country.

In March 2004 Mr Andrew Young, an Australian expatriate Medical Scientist, joined the HIV/AIDS team for 12 months to act as Coordinator, working alongside the Survey Leader and Project Director Dr Farid Basger M.D.

The main focus of the survey team during this first reporting period has been:
(a) to identify the People Living With HIV/AIDS (PLWHA) in Kabul
(b) to identify groups at a high risk of contracting Sexually Transmitted Infections (STI's) and HIV/AIDS in Kabul
(c) to identify which organisations are currently involved with HIV/AIDS work and related work in other fields (including STI's) in Kabul.

During the editing process of this report the team focused their activities on sensitising Mullahs as it was found that they are key stakeholders in awareness raising activities in the future.

Major Findings

The major findings of the survey carried out by *ora international* are as follows:

1. At Risk Groups: Commercial sex workers (CSW's), Police officers, truck drivers and street children, including boot polishers, hotel workers and beggars, are at an increased risk of contracting HIV.

2. Poverty: The vast majority of commercial sex workers surveyed became involved in commercial sex work because of poverty. (90% of survey respondents stated poverty as the reason for their involvement in commercial sex work)

3. Knowledge of HIV/AIDS: No informed knowledge about HIV/AIDS and contraceptives exists amongst the commercial sex workers surveyed and is very limited amongst personnel of mid to lower rank in Government Departments.
   Staff in clinics and hospitals also have limited knowledge regarding HIV/AIDS and at times discriminate against those who are HIV positive (thinking that HIV/AIDS is something the 'foreigners' have brought into the country).

   The commercial sex workers surveyed rarely, if ever, use condoms. Less than 1% of respondents said they use condoms. Of those commercial sex workers surveyed who were presently and actively working, none had been tested for HIV.

4. Screening for HIV: An estimated half of Afghanistan's 44 surgery-performing hospitals do not systematically test blood for HIV before carrying out blood transfusions. Less than 30% of transfused blood is screened for any transmissible agents, including HIV[1].
   In total there are 19 Government HIV testing centres throughout the country, with one testing centre in each province and major hospital; but supplies are limited. This is particularly true of HIV/AIDS testing kits.

5. Existing HIV/AIDS Work: UN agencies support the Ministry of Health (MoH) through staff training and by funding the development and implementation of the National Strategic Plan.
   The National AIDS Control Program of the MoH along with the Ministry of Religious Affairs, UNICEF, UNFPA, CAF and Medair held an inaugural "Religious Leaders National Consultative Conference on HIV/AIDS".
   To date, with the exception of the MoH, only few NGOs such as Khatiz Organisation for Rehabilitation (KOR), a local NGO, and *ora international* have active programs to raise awareness regarding HIV/AIDS.
   Norwegian Church Aid (NCA), Action Aid, Médicins du Monde (MDM), and the Swedish Committee for Afghanistan (SCA) have shown recent interest in carrying out surveys or developing programs for raising HIV/AIDS awareness in Afghanistan.

6. Key stakeholders: In the course of the survey activities we found that it is essential to have the co-operation (or at least the permission) of some stakeholders. It is in particular important to have the co-operation of the Police and Mullahs in order to get, and keep access to the members of high-risk groups.

[1] Ministry of Public Health of the Transitional Islamic Government of Afghanistan, *"HIV/AIDS & STI National Strategic plan for Afghanistan 2003-2007"*, Kabul, Ministry of Public Health of the Transitional Islamic Government of Afghanistan, September 2003, p6.

Recommendations

Based on the outcome of the survey, *ora international's* HIV/AIDS team in Kabul make the following recommendations:

1. Awareness-raising activities should take place, particularly amongst youth; that is people between 15 and 25 years of age.
   This recommendation is based on the following rationale:
   a) Very little knowledge about HIV/AIDS exists in Afghanistan
   b) A large proportion of the population of Kabul falls within this age range
   c) Between these ages considerable physical changes take place and experimental behaviour, including sexual experimentation, develops.
   d) Worldwide HIV/AIDS has spread faster in this age group than in any other

2. Awareness-raising activities and condom distribution should begin amongst groups at high risk of contracting STI's and/or HIV/AIDS. Experience shows that for this work to be effective it needs to be done patiently, as gaining the trust of members of high-risk groups takes a significant amount of time

3. The following improvements in Service Provision for those affected by HIV/AIDS should be made to improve the overall quality of the service provided.
   - A Health and Counselling Centre should be established and Voluntary Counselling and Testing (VCT) implemented.
   - At a later stage antiretroviral drugs should be provided for pregnant women who are HIV positive.
   - Condoms should be distributed free of charge and proper instructions given

4. Solutions to the causes of poverty, vulnerability, marginalisation and powerlessness that result in the spread of HIV/AIDS amongst high-risk groups should be promoted.

5. Accurate and in-depth research and data collection into HIV/AIDS in Kabul should begin, as little is known about the HIV/AIDS situation in Afghanistan.
   To provide a better service to those affected by HIV/AIDS such information is indispensable. For example, accurate data would provide any future awareness-raising programme with a baseline against which the impact of the programmes can be measured.
   For this reason we recommend that:
   - Country-wide sero-prevalence and sentinel site surveillance is instituted
   - A reliable archive with information and references is established.
   - A resource centre with books, publications and the above mentioned archive is built and made available to medical staff in both NGO and government run hospitals and clinics.
   - Secondary data from other NGOs and agencies is obtained
   - Quantitative and qualitative research projects are instituted that will focus on obtaining:
     i) an accurate picture of the AIDS and/or HIV situation in Kabul today
     ii) more information on the true scale of commercial sex work in Kabul and the commercial sex workers involved in it.

6. A greater level of coordination and cooperation between individual NGO's and between government bodies and NGO's should be sought.

7. HIV/AIDS awareness raising activities and service provision should include groups of key stakeholders such as Police officers and Mullahs. Having their co-operation makes access to members of high-risk groups easier and Mullahs could be approached also to assist in reducing the stigma attached to HIV/AIDS and other STDs.

8. Our experience with truck drivers in particular taught the team that employing peer educators is essential for effective awareness raising as the survey team found that they were hardly able to approach the truck drivers at all. The team consisting of doctors were a world apart from them.

Introduction

HIV/AIDS is a global problem. No country, no religion and no culture can claim that they are safe from it. It was estimated that by the end of 2003 there were between 35 and 42 million people worldwide living with HIV/AIDS. In 2003 alone 4.8 million adults and children were newly infected with HIV and 2.9 million died from HIV/AIDS.[2] Moreover this new epidemic is spreading faster than ever before, particularly among the world's poorest nations. At present HIV/AIDS is responsible for 4 times as many deaths per year as was the case a decade ago. Yet most people either don't seem to realise the danger or do not want to think about it.[3]

Afghanistan is a nation in Central Asia bordering six countries: Pakistan, Iran, China, Uzbekistan, Turkmenistan and Tajikistan. Nearly 25 years of warfare, internal conflict and bloodshed, beginning with the Soviet invasion of 1979 and culminating in the removal of the Taliban regime in 2001, has crippled Afghanistan's governmental and non-governmental socio-economic infrastructure. During this time as many as 6 million Afghans fled their homeland seeking refuge from these conflicts[4]. The majority settled in neighbouring Pakistan or Iran, while others moved as far as India, Europe, North America and South America. As one Afghan refugee observed, "Afghans cover the earth like stars cover the sky"[5].

Afghanistan is one of the poorest countries in the world. Porous borders, internal and external displacement, limited health facilities with competing health priorities, a lack of health education, the low status of women, rapidly rising intravenous drug use, and a low literacy rate have all contributed to a situation in which HIV/AIDS has the chance to thrive. Moreover the deployment of thousands of international troops to man the ISAF peacekeeping force and other recent trends such as the establishment of new restaurants and hotels is likely to increase the potential danger HIV/AIDS presents to the Afghan population.

Official Government figures state that the number of HIV cases among Afghans is very low. Nevertheless the increase in cases in the last 2 years should cause great concern. This survey is the first of its kind to be carried out in Afghanistan and although it has its shortcomings, the findings should provide enough evidence to urge action.

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[2] UNAIDS, *"2004 Report on the Global AIDS epidemic"*, Geneva, UNAIDS, 2004, p23.
[3] Dixon, Dr P, *"AIDS and You"*. India, Operation Mobilisation and ACET International Alliance, 2002.
[4] UNHCR, *"Chronology of a Crisis (1973-2002)" in "Return to Afghanistan"* [Online] Available at http://www.unhcr.ch/cgi-bin/texis/vtx/afghan?page=chrono. [2005, April 25th]
[5] "Parvana", in Ellis, D, *"The Breadwinner"*, Oxford, Oxford University Press, 2000, p9



Women with two different hands:

The Taliban regime that ruled Afghanistan from 1996 to late 2001 placed very strict religious, moral and social restrictions on Afghan women. One such restriction was that outside of their homes all women had to wear the Burqa; a kind of dress that covers the whole body with only a small gauze in front of the eyes providing vision.

Faced with these restrictions female commercial sex workers developed a strange technique to find customers; they would wear a very old and dirty burqa so as to appear to passers-by as a beggar. However, they fashioned their hands in 2 very different styles; one hand was dirty, lined and worn; the other was clean and soft with the nails colourfully polished. Should the women suspect that a passer-by sympathized with the Taliban regime's severe moral codes, the dirty hand would be raised and money asked for. If a prospective customer passed, the attractively fashioned hand would appear from under their burqa, absorbing the attention of the passer-by and signaling that she was appealing to more than just his charity. This technique is still used by commercial sex workers in Kabul city today.